MARYLAND CONFIDENTIAL MORBIDITY REPORT (DHMH-1140)

(For use by physicians and other health care providers, but not laboratories. Laboratories use form DHMH-1281)

SEND TO THE HARFORD COUNTY HEALTH DEPARTMENT

STATE DATA BASE NUMBER
(Completed by Health Department)

NAME OF PATIENT – LAST FIRST M

(Maryland law prohibits the reporting of a patient's name for HIV infection.)

DATE OF BIRTH MONTH | DAY | YEAR

AGE

SEX M ☐ F ☐

ETHNICITY (Select independently of RACE)
HISPANIC or LATINO: YES ☐ NO ☐ UNKNOWN ☐

TELEPHONE NUMBERS
Home: Workplace:

RACE (Select one or more. If multiracial, select all that apply)
American Indian/Alaskan Native ☐ Asian ☐ Black/African American ☐
Hawaiian/Pacific Islander ☐ White ☐ Unknown ☐
Other (Specify):

ADDRESS **UNIT#** **CITY OR TOWN** **STATE** **ZIP CODE** **COUNTY**

OCCUPATION OR CONTACT WITH VULNERABLE PERSONS
(Check all that apply - include volunteers)
☐ HEALTH CARE WORKER (Include any PATIENT CARE, ELDER CARE, "AIDES," etc.)
☐ DAYCARE (Attendee or Worker)
☐ PARENT of a child in DAYCARE
☐ FOOD SERVICE WORKER
☐ NOT EMPLOYED
☐ OTHER (SPECIFY):

WORKPLACE, SCHOOL, CHILD CARE FACILITY, ETC. (Include Name, Address, ZIP Code)

DISEASE OR CONDITION

DATE OF ONSET MONTH | DAY | YEAR

ADMITTED YES ☐ NO ☐

DATE ADMITTED MONTH | DAY | YEAR

HOSPITAL

CONDITION ACQUIRED IN MARYLAND
YES ☐ NO ☐ UNKNOWN ☐
(IF NO, INTERSTATE ☐, or INTERNATIONAL ☐)

SUSPECTED SOURCE OF INFECTION

DIED YES ☐ NO ☐

DATE DIED MONTH | DAY | YEAR

PREGNANT
YES ☐ NO ☐ UNKNOWN ☐ NOT APPLICABLE ☐
WEEKS PREGNANT _____ DUE DATE _____

LABORATORY TESTS - VIRAL HEPATITIS

	POS	NEG	DATE
HAV Antibody Total	☐	☐	
HAV Antibody IgM	☐	☐	
HB surface Antigen	☐	☐	
HB core Antibody Total	☐	☐	
HB core Antibody IgM	☐	☐	
HB surface Antibody	☐	☐	
HCV Antibody ELISA	☐	☐	
HCV Antibody RIBA	☐	☐	
HCV RNA (eg., by PCR)	☐	☐	

ALT (SGPT) level _____
ALT – Lab Normal Range: _____ to _____
NAME of LAB: _____

ADDITIONAL LAB RESULTS + PERTINENT CLINICAL INFORMATION + OTHER COMMENTS
(For lab results give SPECIMEN - TEST - RESULT - DATE - NAME of LAB. **Please attach copies of lab reports whenever possible.**)

ACQUIRED IMMUNODEFICIENCY SYNDROME (AIDS) – ADDITIONAL CASE INFORMATION

ONLY physicians should report AIDS. Physicians reporting AIDS should use this form. ONLY laboratories should report HIV infection. Laboratories reporting HIV infection should use form DHMH-1281 and the patient's Unique Identifier instead of the name. Maryland law prohibits reporting of the patient's name for HIV infection.

CONDITIONS	HIV LAB TESTS	DATE	RESULT
WEIGHT LOSS OR DIARRHEA ..... ☐	CD4+ T-cells < 200 per microliter		
SECONDARY INFECTIONS (PCP, etc.) ..... ☐	ELISA		
OTHER CONDITIONS ATTRIBUTED TO HIV INFECTION ☐ (SPECIFY):	WESTERN BLOT		
	OTHER (SPECIFY):		

SEXUALLY TRANSMITTED DISEASE (STD) – ADDITIONAL CASE INFORMATION

SYPHILIS: PRIMARY ☐ SECONDARY ☐ EARLY LATENT (LESS THAN 1 YR) ☐ CONGENITAL ☐ OTHER STAGE ☐ (SPECIFY):

GONORRHEA: UNCOMPLICATED ☐ PID ☐ RECTAL ☐ PHARYNGEAL ☐ OPHTHALMIA NEONATORUM ☐ OTHER ☐ (SPECIFY):

OTHER STD (Specify):

STD LABORATORY CONFIRMATION AND TREATMENT

Specify STD Lab Test (e.g., RPR or VDRL, FTA – ABS, FTA – IgM, Darkfield, Smear, Culture, Other)			STD Treatment Given		
DATE	TEST	RESULT	DATE	DRUG	DOSAGE

TUBERCULOSIS (Suspect or Confirmed) – ADDITIONAL CASE INFORMATION

MAJOR SITE: PULMONARY ☐ EXTRAPULMONARY ☐ ATYPICAL ☐ (SPECIFY) **ABNORMAL CHEST X-RAY:** ☐

COMMENTS:

REPORTED BY	ADDRESS	TELEPHONE NUMBER	DATE OF REPORT
☐ Check here if completed by the Health Department			MONTH DAY YEAR

NOTE: The health department may contact you following this initial report to request additional disease-specific information.

☐ Check here if you need more confidential morbidity report forms

SEND COMPLETED REPORTS TO:
Harford County Health Department
119 S. Hays Street
PO Box 797
Bel Air, MD 21014
or FAX to: **(410) 420-3448**